network
NETWORK 17 APRIL 2007

Sex workers

Can your patients be open enough with you about their sex work, how it fits with their drugs, their lifestyle and their concerns? Dr Brenda Mosdale asks the questions about sex work, with a view to understanding her patient's health, their needs and their choices. Importantly, getting a better understanding and rapport allowing for better services for the women she sees. Ed.

How do you even ask the question? When I began working with street based sex workers in South London, I tried to find out what people knew. I asked GPs, family planning clinics and other health professionals what their experience of working with women who worked in this way. The answer was clear. What women? What sex workers? And most of the people who come to us with drug problems are men.

So I needed to find another way. This time I asked women themselves what their experiences were of drugs, sex

...*continued overleaf*

Consultants, who needs 'em?

As a consultant, Dr Neville Wright tackles head on whether GPs are a threat to the role of the consultant. He strongly argues the case for good primary care based care for the majority of patients, with consultants playing taking on vital roles, though not staying locked up in specialist centres. Ed.

Some of my fellow consultants were clearly worried after my talk at SCAN (Specialist Clinical Addiction Network) last year about facilitating general practitioner involvement with specialist

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We hope you enjoy this issue.

Jean-Claude Barjolin

Editor

Don't forget to become a free member and receive regular clinical and policy updates - the newsletter can also be emailed to you – all for free www.smmgp.org.uk/membership

Editorial

The 12th National Conference in the Management of Drug Users in Primary Care is upon us again, this year hosted in Birmingham, and looking at the theme of 'Collaboration not Competition'. We will be reporting from that in July, but this issue includes related topics by speakers. What a bumpy year it has been for the project and there may just be something in the conference title reflecting that! SMMGP has had a rollercoaster of funding cuts, re-contracting and staff cuts. Happily we can now say as a streamlined project that our free membership base is developing nicely – thank you to all who have joined, but if you haven't joined yet do so now as we still need your support in this volatile funding period **(become a free member at** www.smmgp.org.uk/membership). As members, we hope that you are enjoying our monthly policy and clinical updates.

Thank you to all of you who responded to our Network readership and website surveys. The full survey results can be found in the ***news*** section of **www.smmgp.org** - but we can happily announce that we got lots of offers for future articles (and yes, we will be in touch) and heaps of encouragement and useful suggestions.

With change in the air, I can announce that this will be pretty much last issue as Editor, at least for a while, as I emigrate to Colombia for two years in July. We look forward to shortly introducing you to our new Editor, who will be working with us to produce our next July issue.

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working and service provision, including what they thought of GPs. And they told me. As I sat with them and listened to their stories there were a number of themes that came over again and again.

All the women I met who were both sex workers and misused drugs told me clearly that the drugs had come first. The reason they were on the streets was to pay for the drugs and often for their partner's drugs as well. They spoke of chaotic childhoods, often with drug and alcohol use in the family. Drugs came on the scene for them at varying ages, but often as young as 12 or 13.

As young teenagers they used whatever drugs were around, whatever their boyfriends or others gave them. Heroin came a bit later. There have been a number of studies recently which suggest that often women are injected by their partners. This was certainly the case for many of these women. By the time they knew quite what was happening, they had become dependent.

Women had often known abuse in their childhood and they continued to know violence in their adult relationships with many stories of moving from one abusive partner to another. They sometimes spoke also of the death of partners, not a surprise perhaps given the mortality rate for injecting drug users.

In South London in the mid nineties there were women working the streets who didn't use drugs at all. The main drug used, however was heroin with or without alcohol. Those who had another source of income didn't take to the streets, but for the women I was meeting, sex work was often seen to be preferable to shop lifting or mugging to get money. Besides, as their health got worse, shop lifting became less easy.

However, as we moved into the late '90s, the arrival of crack cocaine changed what had been a relatively stable lifestyle. With crack came chaos. With crack came increase risk taking. From taking a drug to stay well and prevent withdrawals, women described the craving and the different kind of need for this new drug. All the work that had been done about personal safety, risky behaviour and limits that had been set on what they would and wouldn't do went out of the window. Violence on the streets increased. Harm reduction messages were ignored, and women would keep going back out on the streets even when they knew they were at risk, both from clients and from the attention of the police.

With the increase of crack on the streets of London, the average age of women on the streets went down as more, younger women who were primary crack users began working. Homelessness, always a problem, began to increase and the drug services, even those who worked particularly with sex workers, found it more difficult to engage women in treatment. Where a substitute opiate prescription had kept women relatively stable, now all of that was put at risk.

So what about women's experience of treatment services? Most of the women I met had engaged with treatment services at one time or another. So what worked for them? Or what didn't? In terms of drug agencies, women appreciated those services who had set up women only opportunities. Partly this was because they felt that the workers here understood more about how drug misuse affected them. They could talk about their concerns for their children, most of whom were in care in one way or another. Experiences of self help groups such as NA were variable. For some the 12 step approach was a support which helped them. Others couldn't buy in to what was expected of them. The success or otherwise of these approaches seemed to depend on who it was who supported them. That was true of key workers in drug services as well. There were stories of key workers who started enthusiastic but then gave up or lost interest as the problems and relapses and chaos went on and on and on.

So what about GPs? The same is probably true. They were either the best support a woman had or worse than useless. Where things seemed to work was where the doctor, and indeed the whole practice, recognized women as people and didn't just label them as drug users or prostitutes. Many women had mental health problems and these needed to be recognized. They were looking for both knowledge and understanding from health care professionals - and, I suspect, if asked to choose, attitude was more important than expertise. Flexibility, accessibility and awareness - the very idea of choice is not simple for women who are caught up in drugs and working on the streets, but seems to be what's needed. And maybe the kind of service where you don't even need to ask the question because women feel comfortable enough to be open about their lifestyle and health care needs. Or is that an impossible dream?

I do hope not.

Dr Brenda Mosdale, GP, City Reach Norwich,GP NORCAS Lowestoft,RCGP Regional lead Eastern Region, contact brenda.mosedale@nhs,net

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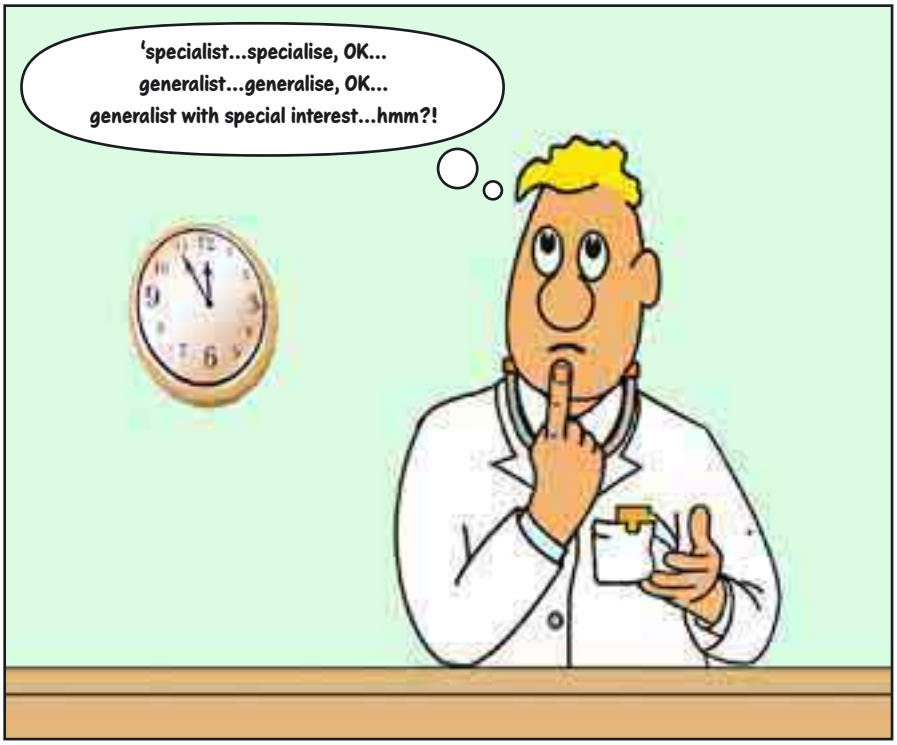
services to treat substance misuse in the surgery. Why do consultants feel threatened sometimes by widespread general practitioner involvement, by my belief that the majority of drug users can be better managed in primary care?

Not an issue of too few customers to justify our vast empires, most specialist services have seen demand greatly outstrip supply and felt overwhelmed by the numbers seeking our help. So why then? Are we afraid that general practitioners will prove to be better at it than us? No chance, consultant arrogance may have taken a battering in the last few years but we're not that demoralised yet! I think we are worried that commissioners or even our own employers don't understand what we do, don't see the point of us. The fear is that once there is enough general practitioners prepared to sign scripts the NHS service can be cheaply replaced by counsellors from non statutory agencies…

I would argue that if the majority of substance misusers are to be safely and effectively managed in primary care consultants and general practitioners need to work together. Why not just keep primary and secondary services separate, sending anyone complicated on to the latter? Because patients like the local non stigmatising service offered at their surgery and don't like having to start all over again, learning to trust staff at a new service. Specialist services may (for good reasons) expect frequent attendance. This is a particular challenge in rural areas for a patient population who even if they have access to a car often cannot legally drive.

So when does a consultant come in handy?

- When a patient has multiple dependencies. Where do you start when someone dependent on opiates, benzodiazepines and alcohol comes asking for a detox?
- In complex psychiatric co-morbidity when the local psychiatric services cannot see past the substance or discharge the patient for using.
- When the substance being misused is unusual (or at least new to you!) i.e. high dose Zolpidem, novel illicit agents from the Internet.



- For a second opinion when your patient is in chaos or just stuck in a rut and unable to make progress with their addiction problem.
- When you inherit a patient with chronic pain on 900 mgs MST for backache or intravenous Diamorphine for migraine (don't ask). How do you tell whether the real problem is addiction, underlying depression, or just severe pain relief which justifies dependence on opiates?
- For reassurance that everything possible has been tried/offered when you meet a patient who has the self-destruct peddle pushed firmly to the floor.
- To help resist pressure to prescribe inappropriately. "But doctor I just can't manage without my six Temazepam at bedtime/ fourteen Heminevrin a day, etc."
- To help introduce clinical innovations. Even a General Practitioner with a special interest has a lot of other stuff to do and to learn, and can't be expected to keep up with everything new in addictions.
- When various professional groups including General Practitioner Registrars need training that established General Practitioners don't have the time to deliver. Consultants can also have a teaching role in the RCGP certificate courses.

I can go on (can't I just) but how is this support to be delivered? Sometimes a phone call is enough, the consultant needs to be easy to find and free enough to take such calls which are not always acknowledged as 'activity' by employing Trusts.

In other situations only a lengthy meeting with the patient will suffice and this needs to be available quickly so the consultant mustn't be bogged down by routine reviewing of straightforward situations.

If the practice based drug workers are from the same organisation as the consultant this provides a good way of delivering input via team supervision. The management advice then is not just the consultant's but the collective wisdom of many addiction practitioners.

To conclude then I believe that addiction consultants are still necessary, but that rather than staying locked up in inaccessible specialist centres they should be working closely with general practitioners so that many more patients can safely enjoy the benefits of primary care based treatment.

Dr Neville Wright

Consultant Addiction Psychiatrist,
Cumbria Community Drug and Alcohol Services

Abstinence – treatment, philosophy, methods

In a second part article Dr Gordon Morse tackles detoxification as a route to abstinence, putting a relevant focus on the individual, philosophical or even spiritual meaning for the patient. His view, that it is the individual's confidence and approach, the significance given to their endeavour, rather than method per se, which is central in successful preparation, aftercare and outcome. Ed.

(Part 2 continued from Network issue16)

In the last article I gave some of the background against which drug users will ask us to help them achieve abstinence: the time to rid ones self, once and for all from dependency on drugs, doctors, pharmacists and services, and the (very real) daily fear of having any of these withdrawn. Perhaps the first thing that the doctor will consider, and the patient will worry about, is the chemical process of detox. I will talk a little about detox later, but I am not going to spend much time discussing it – after overseeing many thousands of detoxes I am firmly of the opinion that the method of detox has very little bearing on the success or failure of achieving durable abstinence.

Preparation for abstinence begins with the debate about what abstinence actually is. Is it to be (at its simplest) abstinence from heroin, but continue on methadone? Or abstinence from all drugs but allow occasional alcohol? And maybe allow cannabis as well? Or maybe leave off all illegal drugs and alcohol, but cigarettes and caffeine are OK? All of these paths can be adopted and are achieved with varying degrees of success, but perhaps paradoxically, it is very often the narrowest (and most puritanical) sense of abstinence, namely from ALL mind affecting substances, which affords the easiest route.

Why is this? Well, at the very least, it is the simplest. It avoids all those judgement calls about what drug is all right and what isn't, when it is all right, how much is all right and so forth – it is completely black and white. And it avoids leaving another addictive avenue to be exploited when one is closed, as frequently can happen with alcohol when opiates are stopped. And setting the hurdle high sets the prize for achieving it high as well: this is a life saving process where the reward of life is used in its fullest sense – in both quantity and quality. It is an admission that although drug use may have been nice, and maybe others can get away with it, for me, I just can't do it any more. And by being so black and white, so it identifies a person: how often our patients are identified as "drug addicts" – as if that defines and explains everything about them. Rather like shedding the pupa's case, so the recovering addict can metamorphose and re-identify himself as abstinent.

This is as much a spiritual journey as anything else – and that is not to confuse it with a religious state as some of the abstinence-knockers would like to do. It can be religious if that works for you – certainly many world faiths embrace abstinence from Methodists to Muslims – but it can be as simple as respect for ones own health and sanity, and the health and sanity of those around us.

Preparation also (vitally) includes education about relapse on loss of opiate tolerance, education on the detox process itself, educating the "significant others" in the person's life to support them through the detox process and the weeks and months that follow, and so forth.

So what of aftercare? Stanton Peele[1] says that all you need do is give them a home and give them a job. William Miller (after Gorsky's work) says that relapse can be avoided in 80% of cases if you deal with their isolation and demoralisation[2]. Then there are psychological therapies such as Marlatt's CBT Relapse prevention model[3], group therapies that addresses interpersonal skills, and drugs such as naltrexone and antidepressants. And of course there are support groups, rehabilitation centres and the 12 Step Fellowships of Narcotics Anonymous, Cocaine Anonymous and others[4]. All of these are invaluable for some and useless to others. Indeed we know that many people achieve durable abstinence with no help from anyone – they just get fed up and get on with it. As GPs we have a good understanding of our patients as people – we have often known them for a long time and can help them make some of these choices about which path to take and what support might fit in with their individual philosophies.

I have left detox to the end of this piece, because it is lowest in terms of importance. Detox from opiates is all about confidence – it is seldom dangerous. There are all manner of detox methods out there: probably the most popular is a slow weaning off methadone over whatever period the patient dictates. Intuitively that seems the easiest, but I am inclined to doubt it. These very slow reductions span periods that frequently stretch motivation beyond its limit, and I have never seen anyone stop smoking by cutting down, cigarette by cigarette, over weeks or months. And the end of these weanings, as every golden milligram is chipped away, seem to be coloured by severe withdrawals the intensity of which follows no physiological logic whatever. It is true that many achieve their abstinence this way, but I suspect that is because tradition has made this the overwhelmingly most popular detox method. No, I am inclined toward the "grasp the nettle" detox over a couple of weeks or so when the patient is at their motivational zenith, and accompanied by as much intensive support as possible. There are various chemical regimen that can aid this process which are to be found in the literature, and for the sake of space, I will leave there for now.

Because abstinence is about everything other than detox: In Abstinence there is something redemptive in it that allows the individual to leave the chaos, pain and shame behind, and start their life again. And that is all about philosophy, not pharmacology.

With thanks to Brahms, whose "German Requiem" was playing as I wrote this.

(A Requiem reflects on a past life whilst welcoming the next – and Brahms was an atheist)

Dr Gordon Morse

GP Medical Consultant to Clouds House, Trust Specialist and Lead GP Clinician for West Wiltshire Specialist Drug and Alcohol Service, RCGP Regional Lead.

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Detoxification

How we do it and what's the evidence

Dr Daphne Rumball and Dr Kedar Kane usefully clarify the clinical principles of detoxification and review the range of therapeutic approaches available to clinicians and patients seeking abstinence. Their view, that the method chosen and principles of detoxification are central in successful pre-detoxification planning, aftercare and outcome. Ed.

The current high rates of illicit drug use show no sign of abating. Increasing numbers of opiate users are on substitute prescriptions. Both populations often seek abstinence. It is essential that clinicians be informed of all therapeutic approaches that may help drug users achieve their goal. We agree with Gordon Morse (see his article in this issue page 4) that the key to lasting abstinence lies in pre-detoxification planning and effective aftercare. However, we believe, the method of detoxification plays an important role in decision making, especially about future attempts, in the event of relapse. Certain methods of detoxification carry risks but have good evidence in promoting abstinence.

The purpose of this article is twofold.

1. **To provide basic principles of detoxification from opiates to maximise successful completion.**
2. **To review the evidence and best practice in the area of opiate detoxification including detoxification complicated by poly drug use, benzodiazepine use, and alcohol dependence.**

On average 3.6 attempts are made per individual to self-detoxify from opiates without medical assistance and in some this may be a pathway to abstinence[1]. It is therefore a therapeutic challenge to enable success.

Good advice is based on a person's motivation (readiness to change)[2], duration, level, and method of use, previous treatments (successes/failures), long term goals, coping strategies and relapse prevention plans. Also of importance are physical and mental health and vulnerability for escalation of other dependencies (particularly alcohol and/or benzodiazepines). Those with severe personality disorders may be best advised to choose maintenance[3].

Detoxification may be undertaken in primary care, specialist home/outpatients/inpatients, residential rehab, according to complexity of need and available support.

The timing of the detoxification will also affect the outcome. The risks involved are of demoralisation and relapse, as well as overdose and death. These risks should be actively considered as those who complete detoxification are at higher risk of serious illness and death[4], overdose being the commonest cause of mortality in drug users, especially after enforced detoxification in prison or hospital.

Poly drug use including alcohol and benzodiazepine use can complicate opiate detoxification; opiate withdrawal symptoms being increased. The risks of mortality are also greater. We therefore highly recommend addressing alcohol and benzodiazepine use before proceeding.

Benzodiazepine use may be falsely seen as a safety net. It is often overlooked but is likely to impede progress in therapy through cognitive impairment, exacerbation of opiate withdrawal symptoms[5], and an increased risk for continuing polydrug use[6].

The various methods of detoxification from opiates include:

1. **Dose reduction from prescription**
2. **Short-term substitute prescription from heroin to methadone / DF118**
3. **Buprenorphine transfer detoxification from heroin or from methadone**
4. **Opiate-free detoxification with symptomatic medication +/- lofexidine (or clonidine)**
5. **Precipitated detoxification using naltrexone**
6. **Anaesthesia assisted detoxification**

Methadone reduction is a standard well known approach applicable in any setting. A variable rate of reduction is made depending on patient and setting. However outcomes have been poor and associated with adverse mood change and relapse[7].

Buprenorphine reduction on the other hand compares well with lofexidine in completion and in abstinence at one month[8].

Substitute prescription of dihyrocodeine and reduction is commonly used in primary care and is also popular with service users due to a perceived shorter duration of withdrawals. However its evidence base is limited[9].

Buprenorphine transfer and reduction is usually undertaken at methadone dose equivalents of less than 30mg/day. However this can be done at higher doses (30-70mg/day) in inpatient settings, wherein buprenorphine 12-16mg may be initiated. Adjunctive lofexidine may be used during transfer[10].

Opiate-free detoxification +/- lofexidine is still commonly used in prisons. Symptom control is poor unless high doses of lofexidine are used (upto 2.4mg / 24 hrs) along with other medication for symptomatic relief, eg loperamide and co-phenotrope, metoclopramide , ibuprofen and short term benzodiazepines for insomnia and anxiety. Lofexidine should be built up prior to stopping opiates as this improves symptom control.

Detoxification precipitated by naltrexone has been shown to reduce overall severity and duration of withdrawal when used concomitantly with lofexidine, compared to lofexidine alone,[11] but is now fairly redundant.

Anaesthesia assisted detoxification has risks that outweigh its benefits. A recent systematic review does not support its use [12,13].

Concerning benzodiazepine withdrawal, good advice is available[14]. DH guidelines[15] advise gradual reduction, and any methadone prescription should be held stable during that time. The BNF[16] highlights the importance of gradual withdrawal and provides conversion charts to diazepam. Sodium valproate can be considered to prevent seizures if complicated or rapid withdrawal is expected. It may be useful for people who are prone to mood swings; the possibility of a Bipolar Disorder should be explored in such cases, (carbamazepine, which induces liver enzymes and reduces serum methadone levels is best avoided).

Detoxification from alcohol is a valuable intervention in opiate dependence to enable opiate re-stabilisation. Standard chlordiazepoxide schedules may be used. The importance of injectable vitamins cannot be ignored as any risk of anaphylaxis is low and the benefits outweigh this risk. Patients are likely to require an increased dose of opiates after alcohol withdrawal, except when vomiting may have been reducing their effective dose.

Relapse-prevention strategies should include the offer of appropriate medication such as naltrexone, acamprosate, disulfiram, depending on substance/s involved.

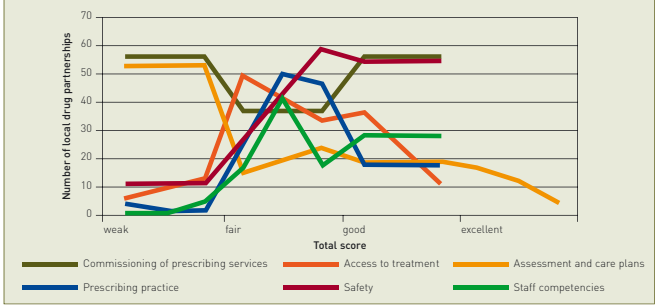
…references on page 15

Improving services for substance misuse

A joint review – National Treatment Agency and the Healthcare Commission

The NTA and the Healthcare Commission have worked together to review drug treatment services nationwide and promote improvements. This involved assessing the performance of 149 local drug partnerships against national standards. The focus was on prescribing drugs safely and appropriately, and planning treatment and coordination of community prescribing services. The review was the first of three reviews of substance misuse to be conducted by the NTA and the Healthcare Commission, the other reviews on reducing harm and commissioning 06/07, and diversity and residential services (inpatient and rehabilitation services) 07/08.

Figure 5: Total distribution of scores for each criteria across community prescribing



The majority of local drugs partnerships scored 'fair' overall, meeting minimum requirements and reasonable expectations against a four-point scale from 'weak' to 'excellent'. Some general areas for strengthening were: in the commissioning of services, including Primary Care Trusts with 63% scoring weak or fair in this area; clinical governance, improved clinical audit, with buprenorphine and methadone prescribing as notable, where insufficient doses to maintain service users and prevent use of street drugs exist. Significant improvements had been made in retention.

The review revealed the positive and crucial benefits of involving service users at all levels: in their own treatment, in planning specific services, and in planning the treatment system at a strategic level. Service user satisfaction is strongly linked to having an up-to-date care plan, which they understand and feel involved in, which meets their individual needs and which is reviewed regularly and as needed. Improvements could also be made in service user involvement, with 48% of local drug partnerships being 'weak' in this area. In particular, the level of risk assessment was low, with 70% of partnerships scoring 'weak' when assessing and managing risks for service users.

Figure 8: Average doses of methadone for maintenance prescribed by local drug partnerships

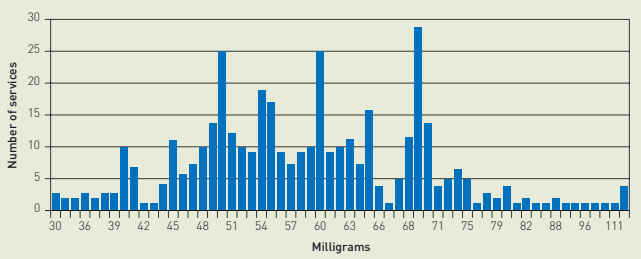
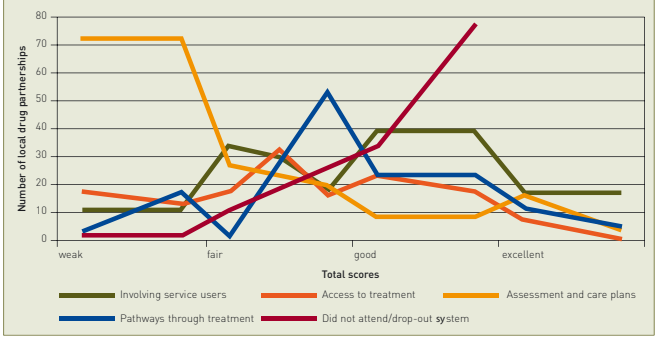


Figure 10: Total distribution of scores for each criteria across care planning and care coordination



Some key recommendation areas included:

- Work to ensure that primary care led or GP prescribing is developed in partnership with specialist services to meet the need of service users, including the need for local and accessible services, some out-of-hours services and appointment flexibility.
- Service users and carers should be involved in all stages of the treatment process, including care plans, planning of new services, feeding back on treatment, and monitoring the quality of services.
- Individual care plan for each service user, involving them in the development and regular review of the plan, with comprehensive assessment, including risks and risk management.
- Assessment and care planning tools reviewed against NTA guidance.
- Clinical governance arrangements, establishment of mechanisms to monitor practice against guidelines, regular reviews or audits to ensure staff are treating service users according to these guidelines, and adequate mix of staff competencies for service provision.
- Monitored action plans developed to address all areas of weak performance .

Figure 13: Drop-out rates per annum

	Retention	Completion
Weak – 2005/2006 rates are lower than the national mid point in 2004/2005 and have not significantly improved in the last 12 months	14%	11%
Fair – 2005/2006 rates are lower than the national mid point in 2004/2005 but have significantly improved in the last 12 months	13%	19%
Good – 2005/2006 rates are higher than 2004/2005 national mid point	72%	69%

Promoting improvements - Strategic health authorities and regional NTA teams are to take responsibility for managing the performance of local drug partnerships (including PCTs) and healthcare organisations, monitor the progress against action plans with the 10% of weakest areas receiving particular scrutiny.

See the full report at:
http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandinspections/improvementreviews/substancemisuse2006-2007.cfm

Jean-Claude Barjolin
SMMGP Network Coordinator

Healthcare Commission

NHS
National Institute for Health and Clinical Excellence

NICE Publications

NICE have been very busy in the substance misuse fields with 4 publications either completed or nearly completed. Here we summarise what the documents say. It should be noted that the first two guidelines are still being revised in response to consultation. SMMGP has sent in a response in conjunction with the RCGP on the first two guidelines, based on comments received by members. Broadly they mostly confirm good practice, however the recommendations regarding contingency management have the potential to be controversial and they are quite prescriptive about what can and cannot be used in detoxification

Psychological interventions guideline:

http://www.nice.org.uk/page.aspx?o=396861

The key priorities for implementation were

- Healthcare professionals should on initial contact and review **involve patients in decision making** regarding their treatment including options for abstinence, maintenance and harm reduction treatments.
- **Brief interventions** - should offer brief interventions to those in limited contact with services. Maximum 2 sessions ranging between 10 and 45 minutes.
- Healthcare professional should routinely provide information about **self-help groups** – the most established are 12 step groups.
- Drug Misuse services should introduce **contingency management programmes.** This should provide incentives (privileges or vouchers) contingent on drug-negative screens. Vouchers should be approximately £5.00, which should increase with each additional continuous period of abstinence. These should be used for those on methadone maintenance and those who primarily misuse stimulants.
- Family or couples-based interventions should be considered for those in close contact with a partner. They should focus on the drug misuse, consist of 12, weekly sessions and be based on cognitive behavioural principles.
- For those at risk of physical health problems, the use of incentives (e.g. £10 shopping vouchers) should be considered to encourage specified harm reduction objectives. These should be one-off or for limited duration. This should be used in particular for hepatitis B/C and HIV testing; hepatitis B immunization; TB tests.

Detoxification guideline

http://www.nice.org.uk/page.aspx?o=402454

The main headlines here were

- **Methadone and buprenorphine** should be first line treatments in detoxification. Patients should normally stay on the drug they are currently being prescribed.
- **Anesthesia or heavy sedation** should not be used.
- **Clonidine** should not be used.
- **Lofexidine** should only be used with informed choice.
- **Dihydrocodeine** should not be routinely used.
- **Naloxone and naltrexone** should not be routinely used to precipitate withdrawals.
- Patients should have had at **least one community detoxification** before being considered for inpatient detoxification.
- **Contingency management** aimed at reducing illicit drug use should be considered both during detoxification and for a period of up to 3–6 months after completion of the detoxification. Based on the same principles and monetary values as outlined above.

Technology appraisals: Final documents published

Naltrexone

http://www.nice.org.uk/guidance/TA115

Naltrexone is recommended as a treatment option for people who have been opioid dependent but who have stopped using opioids, and who are highly motivated to stay free from the drugs in an abstinence programme. It should only be given to people who have been told about the problems associated with treatment, and with proper supervision. Treatment with naltrexone should be given as part of a support programme to help the person manage their opioid dependence. Healthcare professionals should regularly review how well naltrexone is working to help people stay off opioids. If there is evidence that the person has been using the drugs again then healthcare professionals should consider stopping naltrexone treatment.

Methadone and buprenorphine (maintenance)

http://www.nice.org.uk/guidance/TA114

Methadone and buprenorphine (given as a tablet or a liquid) are recommended as treatment options for people who are opioid dependent. A decision about which is the better treatment should be made on an individual basis, in consultation with the person, taking into account the possible benefits and risks of each treatment for that particular person. If both drugs are likely to have the same benefits and risks, methadone should be given as the first choice. Different people will need different doses of methadone or buprenorphine. People should take methadone or buprenorphine daily in the presence of their doctor, nurse or community pharmacist for at least the first 3 months of treatment and until they are able to continue their treatment correctly without supervision. Treatment with methadone or buprenorphine should be given as part of a support programme to help the person manage their opioid dependence.

We feel that these guidelines are to be welcomed, in that they are putting good quality treatment onto a mainstream footing. However we urge caution with regard to the introduction of contingency management, as research has not yet been done in the UK and if not handled correctly could cause considerable political fallout. SMMGP are intending to conduct a membership consultation on this issue which we hope will be of use to policy makers and strategists in the implementation phase of these guidelines.

Jim Barnard
SMMGP Policy Adviser

Building bridges with the criminal justice system – where next in the development of health and social care for offenders?

Dr Mark Williamson, Chair of the RCGP Secure Environments Group, confronts the undeveloped opportunities between health, social care and security agendas. Whilst there is now more familiarity than unease in the overlap of these agendas, he cites the current '…unacceptable level of mortality, morbidity and wasted human potential, suffered by offenders as they leave prisons...' A timely reminder of the gulf in service provision and the reality of unmet needs for this vulnerable population group. Ed.

The challenges

There are 138 Prisons in the UK (128 public, 10 private) housing approximately 80,000 prisoners and the population is slowly rising, in 1992 the figure was 42,000. Of these 5% are female and there are a small number of child prisoners, and approximately 1000 lifers. With about 50% serving less than 6 months there are about 135,0000 prisoners incarcerated per year, (and logically) a slightly smaller number released. These figures mean that there are nearly a million relatives affected by imprisonment annually. England and Wales has the highest imprisonment rate in Western Europe, related to relatively high crime rates though other countries are notably increasing their use of this sentence, e.g. Netherlands. There is an 80% recidivism rate within 2 years of release. The offender population and their families are a significant part of the socially excluded population and they share similar issues of health, health care needs and difficulties in respect of accessing health and social care services.

In 2006 a review by the author of papers relevant to the primary care of offenders for the Sainsbury Centre for Mental health[1], revealed a litany of health and social care need and disadvantage in the offender population. One of the notable features about the needs of offenders is that they are multiple and overlap, for example: mental health and substance misuse; substance misuse and communicable disease; primary care, sexual health and public health; and social exclusion with all. The co-representation of these issues contributes to the tendency in care providers to allow the marginalised and vulnerable, including offenders, to fall between the stools of the care providing structures and systems, classically 'dual diagnosis'. It must equally be credible that this reality will contribute to the recidivism and ill health of prisoners after release.

Some of the social characteristics of offenders:

- Have been in local authority care **13 x more likely than the non- prisoner population.**
- 60 % are unemployed **13 x more likely than the non- prisoner population.**
- Played regular truant **10 x more likely than the non- prisoner population.**
- Suffered school exclusion **20 x more likely than the non- prisoner population.**
- Have a family member convicted **2.5 x more likely than the non- prisoner population.**
- 125,000 children have a family member in prison.
- 42% of released prisoners have no fixed abode.
- 50% re-offend within 2 years.
- 50% of prisoners have reading skills below that of an 11year old.
- 1/3 of offenders debt problems worsen in custody.

Some of the health characteristics of offenders:

- 40% of prisoners declare no contact with primary care prior to detention.
- 50% of prisoners have no GP on release.
- 38% of prisoners are drug users on admission.
- 24% of drug users on admission are injecting drug users – of which:
  - 20% are hep B+ (N= 3,600).
  - 30% are hep C+ (N= 5,400).

- There is high opiate and rising crack dependency amongst prisoners.
- 50,000 prisoners per year access drug detoxification sessions.
- 80% prisoners smoke (40% general population).
- There is a growing elderly population with chronic disease.
- 10% of prisoners have a learning disability.

Some of the mental health characteristics of offenders:

- 90% of prisoners have substance misuse problems, mental health problems or both.
- People who have been in prison are up to 30x more likely than the general population to die from suicide in the first month after discharge from prison.
- Personality disorder is common in the socially excluded and in the prisoner population.
- 9% of the UK prisoner population suffer from severe and enduring mental illness.

Offenders are commonly child victims of abuse and early traumatic events resulting in long standing psychological distress and should generally be seen as vulnerable with services designed accordingly.

Meeting the challenges

Health and social care services for offenders are dependent on a shared approach between security and health and social care. This joint approach depends on shared values, shared principles, and a shared vision of what is needed and how it should be delivered. There are joint programmes of work underway at national, regional and local levels and over the last few years great improvements have been achieved particularly in relation to reducing deaths in custody. However, significant challenges remain and there is now a sense of renewed impetus following the recent transfer of commissioning for prison health care to the NHS. The need to work in partnership and address in particular the needs of younger offenders is highlighted by the above list of issues.

Bridges between the two cultures of security and health and social care are needed at many levels, but the main pillars for these bridges are already in place. On the side of health and social care, the requirement for high levels of security is essential to enable an appropriate therapeutic relationship between the service user and care provider. On the side of security there are many shared core values with the health and social care system in relation to duty of care, respect and building autonomy. In this most challenging of environments there are opportunities for significant synergy of effort and mutual support.

Though there is engagement between the structures and policy streams between health and social care and the criminal justice system there remains a relatively low level of involvement from the service users themselves. This is perhaps understandable but there are significant representative national groups and many individuals who can in the future be invited to contribute more to strategic developments at national regional and local levels.

Primary Care Trusts, in partnership with Local Authorities, are now required to commission and design health care and social services within and without prison but despite the impressive statistics of need there are confounding realities which compromise offenders getting adequate care. Primary care engagement in the care of the socially excluded is generally poor, and many offenders have a distrust of care providers and a fear of stigma and diagnosis[2]. There is commonly poor continuity of health care information on admission to prison, on movement between prisons and on release. There is no national guidance linking services for socially excluded populations and the prison population, despite a significant similarity in the population profiles (though arguably 'Our Health, Our Care, Our Say'[3] partly sets the scene). Current services in prisons tend to be specialist provided for mental health and sometimes substance misuse, they tend to focus on the more seriously ill patients and specialist ways of delivering care. Health and social care for offenders in prisons and upon release faces many uniquely difficult challenges with poor clinical information technology and support systems, staff shortages and poor planning of service integration. Offenders can be challenging to provide care for, with high consulting rates, poor reliability as historians and poor concordance with treatment planning, and health neglect and health damaging behaviours.

There is a relative dearth of research evidence, particularly UK based, about what works and therefore how we should aim to deliver care. This is likely to change as the emergent research networks focusing on offender health get into their stride. There are many reports in the literature about one off projects which have had one effect or another but few which can claim to be clear evidence of best practice. These successful examples tend to share features of integration, continuity of care, multidisciplinary and multi-agency working. The following set of care pathways represent the range of key areas of evidenced need for offenders as a group, and should be considered by commissioners of health and social care provision, but only after a local health care needs assessment exercise.

- Primary care vulnerable and socially excluded GMS.
- Primary care mental health service.
- Secondary Care Mental health service.
- Substance misuse service.
- Sexual health service.
- Infectious diseases service.
- Dental services.
- Optometry services.
- Pharmacy services.
- Health promotion.
- Chronic disease management.
- Learning disability services.
- Social care, Housing, Education, Leisure and Employment.

The recent excellent integrated drug treatment strategy is an example of what is meant here as an 'offender care pathway', explaining what offenders should expect in their treatment and what a good service might look like. The Clinical Management of Drug Dependence in the Adult Prison Setting (IDTS), model covers the following areas:

- Doctor prescribed management of withdrawal at reception.
- Stabilisation for 5 days then, standard or extended detoxification, or maintenance.

...continued on page 13

Diversion – How much do we really know?

Mark Knight uses local research to unravel some of the complex issues relating to diversion, supervision and drug related deaths. He reveals the multifaceted dynamics within local illicit methadone and benzodiazepine markets, and their relationship to service provision and wide-ranging and unmet user needs. Ultimately, a compelling argument for increasing low threshold access and broadening our understanding of what treatment can offer. Ed.

This article briefly addresses a range of issues related to the use and diversion of methadone and benzodiazepines. In addition to considering questions around drug-related deaths and the use of these medications, it asks whether narrowly focusing on the supervision of methadone consumption fully addresses the unmet need indicated by illicit demand.

In the three months prior to intake, just over half of the NTORS sample reported use of diverted benzodiazepines and just under a third of those entering methadone programmes reported use of diverted methadone. At the end of the five year study 7 per cent of those prescribed methadone were also accessing diverted methadone and, despite significant reductions, around 40 per cent were reportedly still using heroin at least once a week [1].

The expansion of drug treatment in the UK was accompanied by a rise in drug-related deaths involving diverted methadone. This in turn led to demands for supervision in order to limit the number of such deaths. Two Australian studies [2] and two English studies [3, 4] found more methadone related overdose deaths among those outside treatment than those in treatment. Yet, as Sunjic and Zador's[5] research indicates, ending methadone diversion would not guarantee an end to methadone related deaths since they found that most of those dying from an accidental overdose whilst in treatment had their methadone use supervised.

There is a very strong case to be made for supervising those that are new to service because of the adverse effect that methadone can have on the liver and the high risk of respiratory depression[6]. Supervision may also benefit more vulnerable and chaotic service users with health and welfare problems [7]. There is also evidence suggesting that the introduction of supervised consumption can have a positive impact on treatment without adversely impacting on death rates [8, 9]. However, in neither of these examples was supervised consumption made compulsory for all clients.

Those opposed to blanket supervision point to evidence that heroin users are more likely to die if not in treatment and argue that rigorous regulation will discourage more chaotic drug users most at risk of overdose [10]. Higher than usual drop out rates accompanied the introduction of supervised maintenance at some services preparing for the NTORS study [11]. In Italy, enforced daily attendance and withdrawal of take-home doses saw a high proportion of deaths among those who left treatment [11, 12, 13].

Those already using heroin may commonly first use methadone that is diverted but accounts of it being diverted to first-time opiate users are extremely rare [14, 15, 16]. Our own local research [17] also found that the use of diverted methadone was essentially limited to heroin using circles, and the role of methadone as a safety net for such people is central to understanding the market for it. Comments from interviewees additionally indicate that the rotational nature of the trade would make it difficult to distinguish buyers from sellers.

The market for benzodiazepines would not appear to be associated with the same 'rotation' of drug debts and demand extends beyond heroin using circles because of their intoxicating effect and versatility in complementing a range of drug using patterns. However, essentially we found that the markets for both drugs involved small networks of individuals who tend not to attract police attention.

In line with previous research [18, 19, 20] we found that diverted methadone is primarily used to manipulate a heroin habit. Whether just to get through the day, or as a complement to other drugs, interviewees' use of methadone appeared functional rather than for pleasure. Local heroin droughts were reportedly very rare, but a preponderance of weak heroin was associated with a need to hold onto and use methadone as a replacement or to compensate for this weakness. Using diverted methadone to prevent withdrawal symptoms (particularly in the morning) also alleviated the need to engage in risky fund raising activities.

There are still probably around a million long-term benzodiazepine users in the UK but drug users face far more difficulty obtaining a script for benzodiazepines than for methadone. This can mean accessing others with scripts; typically 'older people', dependent alcohol users, and those diagnosed with mental health problems. Among heavy end benzodiazepine users we found a willingness to travel to secure supplies and emphasis was placed on maintaining a wide number of individual sources. In contrast, those that did not use such large quantities would appear to have sufficient local contacts.

It is common to find references in the literature to benzodiazepines being combined with other drugs such as methadone and alcohol in order to mimic the effects of heroin. Our interviewees said they used them; with methadone to reduce or eliminate heroin use; with alcohol to aid sleep; to manage the comedown from crack; and immediately prior to injecting heroin in order to boost its potency. Thus both methadone and benzodiazepines seemingly have a role to play when heroin purity is low.

Those using benzodiazepines on a daily basis are far less likely to be retained in methadone treatment [12] and are more likely to inject and share equipment even when prescribed higher doses of methadone [21, 22]. Heroin and methadone users also significantly increase their risk of overdose when using benzodiazepines and alcohol. Indeed, in Australia where nearly 9 out of 10 drug-related deaths over the period of a five year study were attributed to poly drug use; over a quarter had drunk alcohol and over half had taken benzodiazepines [5].

Yet, the literature suggests that the role of heroin, benzodiazepines and alcohol in overdose deaths has been under-reported. In contrast, the role of methadone has been particularly overly emphasized in the context of poly drug deaths involving these substances. Clearly, as Best et al. [12] point out, the risk of overdose increases if methadone is simply added to existing drug repertoires. However, we are still left with the problem identified by Sunjic and Zador [5] of distinguishing those deaths that are methadone caused from those that are methadone related. In other words, we may not necessarily know the contribution methadone may have made to a poly drug death.

Unfortunately many of those most at risk of overdose and in need of drug treatment are those with problems that are so deep-rooted that they either do not seek treatment or are unable to comply with the demands of treatment when they do. The rigid approach of some drug services to attendance and opening times can also result in compliance failures among those drug users that are productively occupied [11].

It is highly likely that many of these people will be accessing diverted methadone and it can be argued that this illicit demand is indicative of unmet need. Nadelmann and McNeely [16] maintain that the best way to eliminate this illicit demand would be to make methadone readily available through legitimate channels that provide a diversity of treatment options including 'low-threshold' programmes. Such programmes are also advocated by Cohen [23] within the context of a model that links a range of solutions for different methadone needs with care and support services that promote social integration. Methadone can be accessed via low-threshold programmes, GPs, or services working towards abstinence that undertake urine tests and remove the non-compliant. Crucially, in the event of failing such rigid programmes a client may revert to less stringent options.

Perhaps instead of just responding to drug-related deaths by focusing on supervision we should look to undercut the illicit market in methadone by providing legitimate low-threshold access to it. Such a proactive response could bring more people into contact with services and facilitate the transmission of information that promotes harm reduction. Perhaps then we might see a greater reduction in the number of lives lost to drug use and a fuller realization of the range of benefits that drug treatment can provide.

Mark Knight is Research and Data Manager for Salford Drug and Alcohol Action Team. He is writing in a personal capacity.

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Tolerance testing troubles

The clinical consensus of the day inevitably get questioned and revised and it usually takes a few controversial and novel clinical perspectives to test or move the boundaries. Dr Adam Bakker seems to have raised some contentious questions and stirred up a bit of debate about the practice, opinion and evidence of induction dosing and tolerance testing. Let the discussion continue… Ed.

If my recent BMJ paper[1] persuaded you to consider some form of methadone tolerance testing (MTT), you should be aware that I stopped using the technique following criticism by the GMC in the Stapleford case. I learned the technique working at Stapleford in 1988 and followed the hearings closely because the doctors concerned are all friends. Although I am by nature an NHS doctor, I enjoyed my time there and it changed my view of addicts. I also discovered that addiction treatment guidelines often relied on opinion and ignored evidence. The contemporary guidelines of 1988 discouraged methadone maintenance treatment but, even then, published research consistently showed clear benefits from this[2]. I am pleased that Stapleford has survived scrutiny by the GMC, although Dr Brewer, its retired founder, was erased from the register.

Dr Zador claimed MTT was beyond the edge of safety[3] and would inevitably lead to more methadone-related deaths. However she quoted no supporting evidence except that it went against evidence-based guidelines. It is hard to accept that our national guidelines are evidence-based when they describe induction dosing based on the severity of withdrawal symptoms. This is irrational because we know that withdrawal severity bears little relationship to daily opiate intake[4]. Nor is there any known evidence in tolerance testing, that it is safer to restrict starting doses to 40mg (20mg-30mg in RCCP guidelines) in poly-drug users who tell you and can clearly demonstrate that they can tolerate 100mg. At Stapleford, some 4000 MTTs were done during two decades without a single fatality. MTT may thus actually be safer than standard induction, where mortality as high as 1:500 has been reported[5].

Paradoxically, my viewpoint is that higher test-doses do not expose patients to bigger risks but merely demonstrate how difficult it would be to kill them using opiates. Giving them an equivalent maintenance dose seems logical and safer. An addict with a big habit who has been prescribed 20mg methadone will not sleep properly unless he has made up the balance, probably with a variety of illicit substances. The induction deaths literature typically involves patients with low or no tolerance or subjects showing multiple substances at post-mortem, often at toxic levels.

Surprisingly, the guidelines lack advice to observe peak-effect while they theoretically allow building up to a dose of 100mg in just four days. Some addicts, seeking intoxicating effects of methadone, could fake withdrawal symptoms and come back at 4 hours requesting more. With a bit of crack in the system, this could be quite convincing. Assessment for signs of withdrawal is very tricky. The symptoms can be severe without clear pathognomic signs. However, when addicts know their word will be put to the test, they give accurate accounts of their habit, just as they give accurate accounts of illicit use when asked to give urine samples, though such accurate information is not necessarily volunteered.

Ten years experience with MTT have taught me that addicts are cautious when starting methadone, generally suggesting doses around half the calculated equivalent of their heroin consumption. They know they will be observed and that naloxone will be used if needed. People requesting big doses typically have high-dose histories, which can usually be confirmed even if supervised consumption cannot. Experienced history-takers should quickly spot discrepancies.

Following the GMC's criticisms, I changed MTT to 'three-day-inductions[6] but my partners feared all tolerance testing. Medico-legally, this makes sense because addicts have higher death-rates than their peers, even if appropriately treated. If there are arguments about the appropriateness of treatment, medico-legal risks are inevitably higher. With such defensive medicine however, addiction treatment may suffer as most treatments are, or once were, controversial. The defensive doctor should thus avoid treating all addicts. I prefer to act in the interest of my patients and would be willing to face the consequences.

My partners prefer total adherence to the guidelines: a moral dilemma for me because in my view, standard induction is less safe. The dogma that no more than 40mg methadone should be used in the first instance is based on the fact that this dose is unlikely to do harm to the opiate-naive. Clearly addicts are not opiate-naïve and since tolerance varies considerably, treating highly tolerant addicts this way seems bizarre. Under-treatment also has risks: higher treatment dropout and associated mortality[7], increased risk of poly-drug death and lower treatment uptake.

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Dr Adam Bakker

GP at Lisson Grove Health Centre. He has been treating addicts in primary care for over 12 years.

Suboxone – so what's new?

Dr Ford reviews the recently licensed Suboxone (buprenorhine and naloxone) and how it differs from Subutex (buprenorphine). It seems the main aim is to reduce injecting misuse, but with new licences in drug dependency not a frequent occurrence, it's worth taking a close look to see what is on offer. Ed.

Suboxone was granted a license and launched in the UK on 1st December 2006. It has already been used extensively in Finland, Norway, Sweden, Australia and the USA. Suboxone contains both buprenorphine hydrochloride (partial agonist) and naloxone hydrochloride dihydrate (antagonist) at a ratio of 4:1 buprenorphine:naloxone. The product is available in both 2 mg tablets (containing 2 mg buprenorphine + 0.5 mg naloxone and 8 mg tablets (containing 8 mg buprenorphine + 2 mg naloxone) for sublingual administration. The price per tablet is equivalent to that of buprenorphine alone (Subutex). As with buprenorphine it needs to be administered sublingually and has a proven clinical efficacy and safety profile.

It has been introduced to discourage the injecting of buprenorphine, which is a common problem, by means of the naloxone component. The rate of injecting in UK of buprenorphine on a regular basis is thought to be about 10% and occasionally as high as 30%. If Suboxone is administered as directed (sublingually) very little of the naloxone reaches the bloodstream and it does not reduce the therapeutic effect of the buprenorphine. However, if Suboxone is injected, the naloxone has a good bioavailability and it quickly precipitates withdrawal effects in opiate-dependent users, reduces the perception of "drug-liking" and presents as generally unpleasant. Hence it is hoped that Suboxone will have a lower misuse potential than buprenorphine alone.

By deterring intravenous misuse, Suboxone may also contribute to a strategy to reduce the transmission of blood borne viruses. It also has a lower street value than buprenorphine alone and so may help to discourage diversion, but this remains to be evaluated.

Suboxone should not be used during pregnancy and the recommendations at present are that if a patient taking Suboxone becomes pregnant, they should be transferred to another maintenance therapy.

Patients being given a prescription for Suboxone should understand that it differs from Subutex in the following ways;

- Appearance – the tablet is a white hexagon (Subutex is a white oval tablet).
- Taste – Suboxone has a lemon-lime flavour.
- Route of administration – patients should be warned that Suboxone should be taken only by the sublingual route: taking it by any other route is likely to precipitate withdrawal.
- Supervision – the decision on level and duration of supervision is a clinical one, but the use of Suboxone may allow an earlier graduation to 'take-home' dosing than would be likely with Subutex or methadone.

Induction

Suboxone differs from Subutex in that;

- The dosing regimen allows for an initial dose on day 1 of 2-4 mg which may be followed by a further dose on the same day of 2-4 mg depending on the patient's requirements.
- Dose can be titrated upwards by 2- 8 mg per day to a maximum daily dose of 24 mg.

Dose reduction

Dose can be reduced by 2-4 mg every 1 to 2 weeks. For patients who may require a lower buprenorphine dose than 2 mg, buprenorphine 0.4 mg sublingual tablets may be used.

Summary

As new licences in drug dependency are so rare, Suboxone should be welcomed to the clinical portfolio. Its clinical and safety profile have been established in other countries, but what does it really add? In the US, buprenorphine alone is not allowed to be prescribed because of its injecting potential, but we yet need to evaluate it and see its relevance to the UK system. If it does reduce injecting misuse potential, reduce HIV and hepatitis transmission, allow for earlier take home dosing and help reduce diversion, then it will be worthwhile. Buprenorphine has become very useful in the treatment of opioid dependency, so lets wait and see where Suboxone fits in.

Dr Chris Ford, SMMGP Clinical Lead

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- Alcohol detoxification.
- Benzodiazepine withdrawal.
- Clinically monitored stimulant withdrawal.
- Joint working between clinical teams, CARATS and DIP teams.
- Progression if required to rehabilitation or therapeutic communities.
- Joint primary care, mental health and substance misuse management for individuals with co-morbidities.
- Ongoing review of extended prescribing.
- Psychosocial support for people with problematic drug use.
- Appropriate facilities and resources
- Evidence base.
- Education and training.
- Continuity.

This model is now increasingly delivered by PCT and prison partnerships.

Conclusion

There is a great deal which could be done, which is currently not being done to meet the health and social care needs of offenders, in the community, in prison and after release, of potential benefit to them, their families and society. To build a more coherent and seamless understanding of the needs of offenders and other marginalised and vulnerable people, we need a broader approach to evidence building and policy development. There is in particular, a moral imperative to try to prevent the continuation of the unacceptable level of mortality, morbidity and wasted human potential, suffered by offenders as they leave prisons.

The most important bridge to build across all care structures including the criminal justice system, is one that will support socially excluded and vulnerable offenders in achieving improved life chances and experience.

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Dr Mark Williamson – Chair of the RCGP Secure Environments Group

Dr Fixit on sex workers who use drugs

Dear Dr Fixit

Amelia has been a patient of mine for about good 20 years. When I first knew her she was a beautiful youngster ready for the fashion industry and with high expectations. When we met about a year ago she came into the DIP service on an ASBO and needing a rapid script. She told me she was working as a street sex worker. I didn't see her again for several months and I heard she was in prison.

Recently she has represented and requested help. Amelia said she was drinking what ever was on offer, usually between 10 and 20 units / day. Her heroin use was between £30 and £50 a day and her crack use was between £50 and £200 a day. She has periods of injecting and of violence towards herself. She has over dosed several times. She had had one admission to hospital for crack psychosis. She told me she now had no outstanding charges but is still working the streets. She was thin and malnourished, had awful teeth, and was scarred, scared, angry, despondent, and dirty.

Her family history is that she was brought up in a family of violence and both her parents were alcoholic. She had been married twice and has 5 children aged between 9 and 21 some with different fathers. She only has some contact with her eldest son who has just come out of prison.

I'm really keen to help her but I feel out of my depth, can you help? How do I prioritise her main issues? Can I work with someone who is so complex in general practice or where can I get help? How can I begin to help Amelia both with her drug and alcohol problem and her sex work?

Answer by Dr Stephen Pick
GPSI in Reading

It is great that you are so keen and want to be involved with Amelia. So often if someone is working in the sex industry, health carers are afraid of them and feel they can't be involved. Sex workers themselves often shy away from helping agencies. This is an important first step for someone who may feel too scared to approach you due to her previous bad experiences with the medical profession and others. She must have already built a good relationship with you and you will be able to use that to help her.

I agree that this is a complex case and one where the feeling of panic is near! But YES Amelia is someone you can work with.

I try and break things down, so it seems more manageable and then prioritize the problems. You need to work out your priorities AND HERS. What the problems are, what you can deal with in your surgery, what you need more help with, and balance it with what SHE wants and sees as most urgent. It's also important to work within your comfort zone and not to be shocked by what she tells you and to sensitively ASK her what is happening and what she wants. The dialogue with her and engaging "where she is at" is so important. She wants help and will appreciate what you are doing. It is important to realise that you need not work alone and to use the Shared Care Scheme in your area and the Specialist Service as you will need to link in with them as quickly as possible. They may know Amelia and will be glad to know you are prepared to be involved and will be glad of your expertise and support.

Some of the problems are:

1) Her sex working and the multitude of issues around that – safety , violence, a safe house to live in, is she wanting to find an exit from sex working, is her pimp/partner causing problems? Is someone injecting her?

2) Her crack use. This will be strongly linked into her sex working.

3) Her heroin use and dependence.

4) Her injecting. The risks involved with that and the vulnerabilities associated with it.

5) Her general health, safety, housing and nutritional needs and the obvious fact that she is not caring for herself.

6) Her alcohol intake.

7) She has other mental health issues related to her drug use, and those that are not so clearly definable owing to all the severe abuse, fear, and deprivation that she has gone through.

Some of these will be interlinked. Certainly her sex working will be entwined with them all. There is much to helping Amelia, and you as the GP have a vital role in coordinating and delegating to the various services as well as looking after her general medical needs. The specialist service is vital. They will help you get Amelia onto a methadone script. I would not suggest buprenorphine for her, as she has been using for so long, is injecting, and emotionally isn't ready for that clarity and lack of a "warm cotton wool feeling". You as the GP have so much to offer. You will be able to give her general health care advice such as help with diet and nutrition, caring for herself, BBV advice, giving her condoms if they are available, doing a smear, making sure she is Hep B and A immunised and sign posting to a GUM service and a dentist. There is much harm reduction work that you can do that need not take up too much time. You want to make sure she returns and remains engaged with you.

Other services that can help apart from the Specialist Service will be, Housing, Crack Services, Women's Refuge, there may be a Sex Workers Project locally, the CMHT, the Alcohol Service, your practice nurse, street services, somewhere for her to get food and safety. If she wants to exit from street sex working she may need protection from her pimp/partner or others whom she is involved within the sex industry and crack and heroin business. Some areas have an 'Ugly Mug' service to provide working girls with information on violent punters.

At some time it may be helpful to look with her at how this all started and she may want some therapy to address these issues.

This is a holistic multidisciplinary approach.

You ask how you can begin to help Amelia.

The answer is – 'To BEGIN and ASK.'

Dr Fixit on DIP…

Dear Dr Fixit

I have a number of patients that I prescribe for who are also involved with the criminal justice system. I thought I understood the system but recently almost every time I see one of these patients the name or function seems to change! Can you explain what is DIP and how DTTO's fit in. Also when an order is breached, such as additional drugs in the urines nothing seems to happen to them (which personally is fine by me) but what is suppose to happen and how successful is the whole setup?

Hope you will be able to clarify for me.

Answer by Dr Linda Harris
Director RCGP Substance Misuse Unit

Thanks for your question I quite agree with you about the confusing nature of the criminal justice care pathways and the accompanying sea of acronyms that seem to change with the wind.

DIP stands for Drugs Intervention Programme, a home office funded end to end treatment system with the strap line "out of crime and into treatment". They are sometimes referred to as rapid prescribing services. Clients can be legitimately referred into a DIP service if:

They are recently referred from prison, If they have been arrested for a trigger drug related offence and subsequently Tested positive for a class A drug, If they are seen in the cells and request an assessment though an arrest referral worker. On some occasions an individual can be assertively signposted into treatment by cold calling by the police or probation service based on local intelligence

DIP teams comprise drugs workers and offender managers (previously called probation officers), service working in partnership with case trackers and members of the local police force. Most teams also have dedicated housing support workers and workers able to assess and signpost substance misusers from the prison cells.

The Drug Treatment and Testing Order (DTTO) which has now been superseded in sentencing terms by the Drug Rehabilitation Requirement or DRR is a probation order with a condition of treatment and clients have to be sentenced through the courts to receive one. They are normally six month orders but can run for longer and can be combined with other sentences such as an Anti Social Behaviour Order (ASBO).

Individuals who enter treatment though the DIP care pathway who end up being charged for a drug related criminal offence can be assessed by a probation officer for a DRR and it is considered good practice for DIP to relate to DRR in this way.

An order is breached when an individual fails to comply with the conditions of the order, this may be for a variety of reasons from failure to attend appointments to failure to achieve the agreed and specified treatment goals or re-offending.

A breach requires the individual to return to court for the case to be reviewed. The serious nature of the order means that imprisonment is a potential outcome of a breach (which, after all, is an additional crime over and above the one for which the individual was sentenced). On many occasions the court will respond to the breach by sending the client back to treatment having set some new and more stringent goals.

In terms of effectiveness there is much evidence to suggest that where there is a DIP programme crime has fallen – what is not as clear from the research is how much is due to intensive policing rather than rapid access to prescribing.

Whilst criminal justice care pathways have in many areas helped to address long waiting times and promoted the development of a multi agency approach, I can't understand how its has come about that despite the additional millions of pounds spent on community drug treatment we have overcrowded prisons.

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Dr Daphne Rumball Consultant in Addictions Psychiatry

Dr Kedar Kale SpR in Addictions Psychiatry

Alcohol and Drugs Service, Norfolk and Waveney Mental Health Partnership Trust

7 Unthank Road, Norwich NR2 2PA. Email Daphne.Rumball@nwmhp.nhs.uk

BULLETIN BOARD

SMMGP: 2nd Annual Conference on Shared/Primary Care Based Treatment for Drug Users in the South West Region

Venue: Lyngford House Conference Centre, Taunton. Date: Tuesday 3 July 2007, 9.00am-4.30pm Fee: £75.00 per participant inclusive of lunch & refreshments.

Promoting effective partnership and collaborative working. Models of shared/primary care services.

Therapeutic interventions. National developments & current issues. Launching the South West Region Shared Care Forum: The regional event for all those developing, providing and supporting services, including GPs, consultants/trust specialists, shared care co-ordinators and workers, nurses and primary care staff, managers, pharmacists, commissioners, service users. Plenary, group discussions and workshops - networking, learning, sharing common concerns, challenges and solutions.

Keynote speaker: Dr Susi Harris GP/NTA Clinical Team/Clinical lead in Substance Misuse for Calderdale.

The conference flyer and application form can be downloaded from www.SMMGP.org events Please complete and return the Application Form by **Friday 1st June 2007** to **smmgp@freeuk.com** For further information, please contact the conference co-ordinator: **Annas Dixon SMMGP Associate Advisor Tel: 07736 769 357 E-mail: annasdixon@btinternet.com**

Be part of the change 2007 is a critical year for the UK drugs field – DrugScope

DrugScope is running regional focus groups as free, informal half-day events, starting with lunch at 1.00pm and going on through the afternoon. You do not have to be a DrugScope member to take part and you may want to include a colleague from one of the generic services you work with like health, housing or social services.What policy means to you. What the challenges are that you are facing over the next five years. In what ways you want DrugScope to help and influence on your behalf. How you would like to be involved in DrugScope. Focus group dates and venues are as follows, but we are also looking to arrange similar events in Scotland and N. Ireland:

24 Apr 2007: Sheffield - Friends Meeting House, St James Street, S1 2EW
27 Apr 2007: Newcastle - Friends Meeting House, Archbold Terrace, NE2 1DB
30 Apr 2007: Manchester - Friends Meeting House, Mount Street, M2 5NS
02 May 2007: Liverpool - The People's Centre, Mount Pleasant, L3 5SD
04 May 2007: Norwich - "The Garage" Chapel Field North, NR2 1NY
08 May 2007: Cardiff - Children in Wales, Windsor Place, CF10 3BZ

Simply e-mail us at the address below with your name(s), contact details and the event you wish to attend and we will confirm arrangements. Numbers are limited, so please contact us soon. **E-mail: consultations@drugscope.org.uk** For more information, http://www.drugscope.org.uk/

SMMGP National Primary Care Development Conference

Bringing it Together **– Effective primary care based drug treatment services 07 and beyond**

Following on from the success of last years conference (Shared Care Co-ordinators) SMMGP in association with Sexual Health on Call (SHOC) are organising a second conference for all those involved in the **development of treatment services in primary care.** The date is the 21st September at the Burlingrton Hotel, Birmingham, cost £100. For more information including registration please contact Brian Whitehead at SHOC on SHOC@gp-E84025.nhs.uk or download application from www.smmgp.org.uk.

RCGP Upcoming Professional Development Events 2007

8 May (London) - **Update on Hidden Harm and Child Protection**
Thursday 19 June (London) - **National Training events for GPs wishing to complete the Part 1**
27 June (Manchester) - **Update on Crack and other stimulants**
Friday 20 July 2007 (Southwark) - **Secure Environment - Part 1**
18 September - **Update on Dual Diagnosis**
8 October (RCGP London) - **Screening and Briefing Intervention for Alcohol**
23 October (RCGP London) - **Update on Prescribing for Opiate Users**
Wednesday 14 November , London - Nati**onal Training events for GPs wishing to complete the Part 1**

See www.rcgp.org for more information or contact Jo Betterton, the SMU Project Manager (jbetterton@rcgp.org.uk), **020 7173 6095** to book places on any of the upcoming CPD days.

Hepatitis C Guidelines Launch

Prevention, testing, treatment and management of hepatitis C

Including launch of 'Guidance for the prevention, testing, treatment and management of hepatitis C in Primary Care'

London on Tuesday 29th May 2007 The Globe Theatre, Bankside, SE1 9DT and in York on Tuesday 17th July 2007 Royal York Hotel,

A day to update primary care professionals on the prevention, testing and management of hepatitis C

Hepatitis C is an under-diagnosed and under- treated important cause of morbidity and mortality. It is a common and potentially curable disease, but only 1-2% of infected people are currently receiving NICE recommended therapy. Every general practitioner is likely to have between 8 to 18 infected individuals. Many of these patients may be undiagnosed and testing for this in General Practice must be increased.

Speakers include: - Professor Graham Foster Consultant Hepatologist London, Dr Chris Ford GP & SMMGP Clinical Lead, Kate Halliday SMMGP, Dr Stephen Willott GPwSI Windmill Practice & Drugs Lead RCGPSDHIVTG, Kate Jack Hepatitis Nurse Specialist Nottingham City Hospital and Windmill Practice, Sebastian Saville Release

Cost for the day: Past and current certificate candidates & RCGP Members £130.00

All other delegates £150.00

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Managing Editor:
Jean-Claude Barjolin
Network Coordinator, SMMGP

Advisory Editor:
Dr Chris Ford
Clinical Lead, SMMGP

Associate Editor:
Jim Barnard
Policy Officer, SMMGP

Contact:
SMMGP,
c/o Bolton, Salford and Trafford Mental Health NHS Trust,
Bury New Road,
Prestwich,
Manchester
M25 3BL

Tel: 0161 772 3546

email: Jean-Claude Barjolin
pcnet@smmgp2.demon.co.uk

Jim Barnard
smmgp@freeuk.com

website: www.smmgp.org.uk

NETWORK NEWSLETTER
IS SPONSORED BY
SCHERING-PLOUGH LTD
Network ISSN 1476-6302

SMMGP works in partnership with

National Treatment Agency for Substance Misuse